

<b>Case Number:</b>	CM15-0109127		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	12/03/2014
<b>Decision Date:</b>	09/08/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 47-year-old female, who sustained an industrial injury on 12/3/2014. She reported neck and left shoulder pain. The injured worker was diagnosed as having clinical evidence of disc herniation of the cervical spine at C5-6, and full thickness tear of the left shoulder rotator cuff with adhesive capsulitis. Treatment to date has included medications, X-rays, physical therapy, injections, rest, magnetic resonance imaging, and evaluations. The request is for left shoulder rotator cuff repair, sutures and screws, interferential unit, pain pump, and cold therapy unit. On 4/27/2015, she complained of neck pain and left shoulder pain. Physical examination revealed a normal cervical spine posture, tenderness along the trapezius muscle with noted spasm, full range of motion, and the left shoulder is noted to have marked tenderness and limited range of motion. Testing revealed positive impingement tests I and II. The treatment plan included: left shoulder surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**One (1) diagnostic and operative arthroscopy of the left shoulder with rotator cuff repair with capsular release and manipulation under anesthesia possible biceps tendon tenodesis and possible mumford procedure: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Surgery for adhesive capsulitis.

**Decision rationale:** CA MTUS/ACOEM Guidelines are silent on the issue of surgery for adhesive capsulitis. According to the ODG Shoulder section, surgery for adhesive capsulitis under study, the clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. The guidelines recommend an attempt of 3-6 months of conservative therapy prior to contemplation of manipulation and when range of motion remains restricted (abduction less than 90 degrees). In this case, there is insufficient evidence of failure of conservative management in the notes submitted from 4/27/15. Until a conservative course of management has been properly documented, the request is not medically necessary.

**One (1) sutures and screws:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Surgery for adhesive capsulitis.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**30 day rental of interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ICS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 117-118.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**One (1) purchase of pain pump:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative pain pumps.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**One (1) purchase of cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.